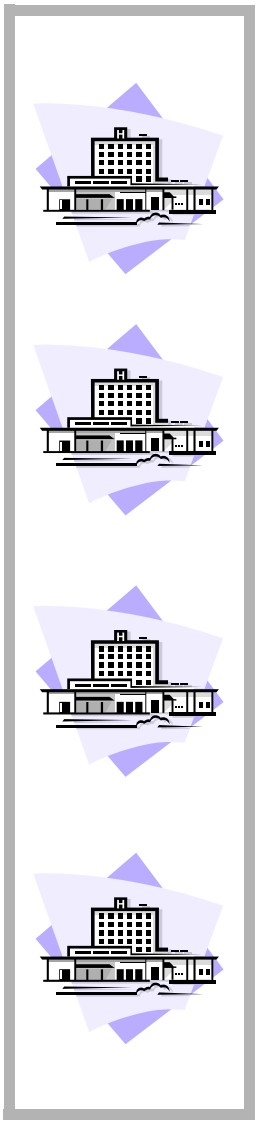

Hospital Outpatient Services

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

August 2004

This publication supersedes all previous Hospital Outpatient Services handbooks. Published by the Montana Department of Public Health & Human Services, August 2003.

Updated April 2004, August 2004.

My Medicaid Provider ID Number:

MONTANA
Department of Public Health & Human Services

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Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about eligibility, payments, denials, general claims questions, PASSPORT questions, or to request provider manuals or fee schedules:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena
(406) 442-4402 Fax

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Medicaid Client Help Line

Clients who have Medicaid or PASSPORT questions may call the Montana Medicaid Help Line:

(800) 362-8312

Send written inquiries to:

PASSPORT To Health
P.O. Box 254
Helena, MT 59624-0254

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

PASSPORT Program Officer

Send inpatient stay documentation to:

PASSPORT Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Team Care Program Officer

For questions regarding the Team Care Program:

(406) 444-4540 Phone
(406) 444-1861 Fax

Team Care Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Nurse First

For questions regarding Nurse First Disease Management or the Nurse Advice Line, contact:

(406) 444-4540 Phone
(406) 444-1861 Fax

Nurse First Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

ACS EDI Gateway

For questions regarding electronic claims submissions:

(800) 987-6719 Phone
(850) 385-1705 Fax

ACS EDI Gateway Services
2324 Killearn Center Blvd.
Tallahassee, FL 32309

Provider Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the G*eneral Information For Providers* manual.

CLIA Certification

For questions regarding CLIA certification, call or write:

(406) 444-1451 Phone
(406) 444-3456 Fax

Send written inquiries to:

DPHHS
Quality Assurance Division
Certification Bureau
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

Diabetic Education Services

The hospital's diabetic education protocol must be approved by:

Medicare Part A Program
P.O. Box 5017
Great Falls, MT 59403

Hospital Program Officer

(406) 444-4540 Phone
(406) 444-1861 Fax

Send written inquiries to:

Hospital Program Officer
DPHHS
Medicaid Services Bureau
P.O. Box 202951
Helena, MT 59620-2951

Technical Services Center

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below and ask for the Medicaid Direct Deposit Manager.

(406) 444-9500

Lab and X-ray

Public Health Lab assistance:

(800) 821-7284 In state
(406) 444-3444 Out of state and Helena

Send written inquiries to:

DPHHS Public Health Lab
1400 Broadway
P.O. Box 6489
Helena, MT 59620

Claims for multiple x-rays of same type on same day, send to:

DPHHS
Lab & X-ray Services
Health Policy & Services Division
P.O. Box 202951
Helena, MT 59620

Chemical Dependency Bureau

For coverage information and other details regarding chemical dependency treatment, write or call:

(406) 444-4540 Phone
(406) 444-9389 Fax

Send written inquiries to:

Chemical Dependency Bureau
Addictive and Mental Disorders Division
DPHHS
P.O. Box 202905
Helena, MT 59620-2905

Prior Authorization

The following are some of the Department's prior authorization contractors. Providers are expected to refer to their specific provider manual for prior authorization instructions.

Surveillance/Utilization Review

For prior authorization for specific services, contact SURS at:

(406) 444-0190 Phone
(406) 444-0778 Fax

Send written inquiries to:
Surveillance/Utilization Review
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

Mountain-Pacific Quality Health Foundation

For questions regarding prior authorization for transplant services, private duty nursing services, medical necessity therapy reviews, and emergency department reviews:

Phone:
(800) 262-1545 X5850 In and out of state
(406) 443-4020 X5850 Helena

Fax:
(800) 497-8235 In and out of state
(406) 443-4585 Out of state and Helena

Send written inquiries to:

Mountain-Pacific Quality
Health Foundation
3404 Cooney Drive
Helena, MT 59602

First Health

For questions regarding prior authorization and continued stay review for selected mental health services.

(800) 770-3084 Phone
(800) 639-8982 Fax
(800) 247-3844 Fax

First Health Services
4300 Cox Road
Glen Allen, VA 23060

Key Web Sites

Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.state.mt.us	**Select *Human Services* for the following information:** • **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information and a link to the Provider Information Website. • **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • **DPHHS:** Latest news and events, DPHHS information, services available, and legal information. • **Health Policy and Services Division:** See list under **Health Policy and Services Division** below.
Provider Information Website www.mtmedicaid.org	• Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • PASSPORT and Team Care Information • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • HIPAA Update • Newsletters • Key contacts • Links to other websites and more
CHIP Website www.chip.state.mt.us	• Information on the Children's Health Insurance Plan (CHIP)
Centers for Disease Control and Prevention (CDC) website www.cdc.gov/nip	Immunization and other health information
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides • FAQs • Related Links

provided. See *When to Bill a Medicaid Clients* in the *Billing Procedures* chapter of this manual.

- Donor search expenses
- Autopsies
- Medicaid does not cover services that are not direct patient care such as the following:
  - Missed or canceled appointments
  - Mileage and travel expenses for providers
  - Preparation of medical or insurance reports
  - Service charges or delinquent payment fees
  - Telephone services in home
  - Remodeling of home
  - Plumbing service
  - Car repair and/or modification of automobile

Use the current fee schedule for your provider type to verify coverage for specific services.

Importance of fee schedules

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in this chapter. Use the current fee schedule in conjunction with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service. Current fee schedules are available on the Provider Information website (see *Key Contacts*). For disk or hard copy, contact Provider Relations (see *Key Contacts*).

Coverage of Specific Services (ARM 37.86.3002)

The following are coverage rules for specific hospital outpatient services.

Abortions (ARM 37.86.104)

Abortions are covered when one of the following conditions is met:

- The client's life would be endangered if the fetus is carried to term.
- The pregnancy is the result of rape or incest.
- The abortion is determined by the attending physician to be medically necessary, even if the client's life is not endangered if the fetus is carried to term.

A completed *Medicaid Recipient/Physician Abortion Certification* (MA-37) form must be submitted with every abortion claim or payment will be denied (see *Appendix A: Forms*). Complete only one part (I, II, or III) of this form; the part used must be clearly indicated on the form. This form is the only form Medicaid accepts for abortion services.

When using mifepristone (Mifeprex or RU 486) to terminate a pregnancy, it must be administered within 49 days from the beginning of the last menstrual period by or under the supervision of a physician who:

- Can assess the duration of a pregnancy.
- Can diagnose ectopic pregnancies.
- Can provide surgical intervention in cases of incomplete abortion or severe bleeding, or can provide such care through other qualified physicians.
- Can assure access to medical facilities equipped to provide blood transfusion and resuscitation.
- Has read, understood and explained to the client the prescribing information for mifepristone.

Air transports

Air transport providers must be registered with Medicaid as an ambulance provider. Claims for these services are billed on a CMS-1500 claim form. See the *Ambulance Services* manual available on the Provider Information website (see *Key Contacts*).

Chemical dependency treatment

Medicaid covers chemical dependency treatment services. For coverage details, contact the Chemical Dependency Bureau (see *Key Contacts*).

Diabetic education

Medicaid covers diabetic education services for newly diagnosed and/or unstable diabetics (e.g., a long-term diabetic with current management problems). The diabetic education protocol must meet the following Medicare Part A requirements:

- The program must train and motivate the client to self-manage their diabetes through proper diet and exercise, blood glucose self monitoring, and insulin treatment.
- The plan of treatment must include goals for the client and how they will be achieved, and the program duration must be sufficient to meet these goals.
- The physician must refer only his or her clients to the program.
- The program must be provided under the physician's order by the provider's personnel and under medical staff supervision.
- The education plan must be designed specifically for the client to meet his or her individual needs. Structured education may be included in the plan, but not substituted for individual training.

Donor transplants

Medicaid covers harvesting from organ donors and transplants, but does not cover expenses associated with the donor search process.

Before performing a sterilization, the following requirements must be met:

- The client must have the opportunity to have questions regarding the sterilization procedure answered to his/her satisfaction.
- The client must be informed of his/her right to withdraw or withhold consent anytime before the sterilization without being subject to retribution or loss of benefits.
- The client must be made aware of available alternatives of birth control and family planning.
- The client must understand the sterilization procedure being considered is irreversible.
- The client must be made aware of the discomforts and risks which may accompany the sterilization procedure being considered.
- The client must be informed of the benefits and advantages of the sterilization procedure.
- The client must know that he/she must have at least 30 days to reconsider his/her decision to be sterilized.
- An interpreter must be present and sign for those clients who are blind, deaf, or do not understand the language to assure the person has been informed.

Informed consent for sterilization may not be obtained under the following circumstances:

- If the client is in labor or childbirth.
- If the client is seeking or obtaining an abortion.
- If the client is under the influence of alcohol or other substance which affects his/her awareness.

Medically Necessary Sterilization

When sterilization results from a procedure performed to address another medical problem, it is considered a medically necessary sterilization. These procedures include hysterectomies, oophorectomies, salpingectomies and ochiectomies. Every claim submitted to Medicaid for a medically necessary sterilization must be accompanied by one of the following:

- A completed *Medicaid Hysterectomy Acknowledgement* form (MA- 39) for each provider submitting a claim. See *Appendix A Forms*. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (section B) or life-threatening emergency (section C) exists, the client must sign and date section A of this form at least 30 days prior to the procedure (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). The client does not need to sign this form when sections B or C are used. Please refer to

Appendix A for more detailed instructions on completing the form.

- For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
    - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
    - The reason for the hysterectomy was a life-threatening emergency.
    - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

Therapy services

In an outpatient department, physical, occupational, and speech/language therapy services are limited to 40 hours each during a state fiscal year (July 1 - June 30) for adults age 21 years and older. Children may qualify for more than 40 hours if medically necessary, and prior authorization is required (see the *PASSPORT and Prior Authorization* chapter in this manual).

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

Lab and imaging services are the only hospital outpatient services available for clients enrolled in MHSP. This limit does not apply to Medicaid enrolled clients receiving mental health services. Providers will find more information on Medicaid mental health services and MHSP services in the *Mental Health* manual available on the Provider Information website (see *Key Contacts*).

Children's Health Insurance Plan (CHIP)

The information in this chapter does not apply to CHIP clients. Hospital outpatient services for children with CHIP coverage are covered by the BlueCHIP plan of BlueCross BlueShield of Montana (BCBSMT). For more information contact BCBSMT at (800) 447-7828 x8647 or (406) 447-8647. Additional information regarding CHIP is available on the *CHIP* website (see *Key Contacts*).

MONTANA
Department of Public Health & Human Services

PASSPORT and Prior Authorization

What Are PASSPORT, Team Care and Prior Authorization? (ARM 37.86.5101 - 5120)

PASSPORT To Health, the Team Care Program and prior authorization (PA) are three examples of the Department's efforts to ensure the appropriate use of Medicaid services. In most cases, providers need approval before services are provided to a particular client. PASSPORT approval and prior authorization are different, and some services may require both. A different code is issued for each type of approval and must be included on the claim form (see the *Completing A Claim* chapter in this manual).

- ***PASSPORT To Health Managed Care Program*** is Montana Medicaid's Primary Care Case Management (PCCM) Program. Under PASSPORT, Medicaid clients choose one primary care provider and develop an ongoing relationship that provides a "medical home." With some exceptions, all services to PASSPORT clients must be provided or approved by the PASSPORT provider. Most Montana Medicaid clients must participate in PASSPORT with only a few exceptions. The PASSPORT Program saves the Medicaid Program approximately $20 million each year. These savings allow improved benefits elsewhere in the Medicaid Program. For more information on PASSPORT To Health, see the *General Information For Providers* manual, *PASSPORT and Prior Authorization* chapter.
- ***Team Care*** is a utilization control and management program designed to educate clients on how to effectively use the Medicaid system. Clients with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. These clients must enroll in PASSPORT, select a PASSPORT primary care provider (PCP) and a single pharmacy, and call the Nurse First Advice Line prior to accessing Medicaid health services (except for emergency services). These clients receive extensive outreach and education from Nurse First nurses and are instructed on the proper use of the Montana Medicaid healthcare system. Team care is a component of the PASSPORT program, and all PASSPORT rules and guidelines apply to these clients. For more information on the Team Care Program and Nurse First, see the *General Information For Providers* manual or the *Team Care* page on the Provider Information website (see *Key Contacts*).
- ***Prior authorization*** refers to a list of services. If a service requires prior authorization, the requirement exists for all Medicaid clients. When prior authorization is granted, the provider is issued a PA number which must be on the claim. See *Prior Authorization* later in this chapter for instructions on how to obtain prior authorization for covered services.

Different codes are issued for PASSPORT approval and prior authorization, and both must be recorded on the UB-92 claim form.

Medicaid does not pay for services when prior authorization or PASSPORT requirements are not met.

In practice, providers will most often encounter clients who are enrolled in PASSPORT. Specific services may also require prior authorization regardless of whether the client is a PASSPORT enrollee. For example, if a PASSPORT client comes to a plastic surgeon requesting a cosmetic procedure, then PASSPORT approval is required from the PASSPORT provider and prior authorization is required from the Department's SURS unit. Refer to *Prior Authorization* later in this chapter and the fee schedules for PA requirements. PASSPORT approval requirements are described below.

PASSPORT information for all providers

Client eligibility verification will indicate whether the client is enrolled in PASSPORT. The client's PASSPORT provider and phone number are also available, and the client may have full or basic coverage. Instructions for checking client eligibility are in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.

To be covered by Medicaid, all services must be provided in accordance with the requirements listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in the *Covered Services* chapter of this manual. Prior authorization requirements must also be followed.

PASSPORT and emergency services

PASSPORT provider approval is not required for services provided in the emergency department (ED) for any Medicaid client. However, if an inpatient hospitalizatoin is recommended as post stabilization treatment, the hospital must contact the client's PASSPORT provider (see *Emergency department visits* in the *Covered Services* chapter of this manual).

PASSPORT and Indian Health Services

Clients who are eligible for both Indian Health Services (IHS) and Medicaid may choose IHS or another provider as their PASSPORT provider. Clients who are eligible for IHS do not need a referral from their PASSPORT provider to obtain services from IHS. However, if IHS refers the client to a non-IHS provider, the PASSPORT provider must approve the referral.

Getting questions answered

The *Key Contacts* list (at the front of this manual) provides important phone numbers and addresses. Provider and Client HelpLines are available to answer almost any PASSPORT or general Medicaid question. You may call the PASSPORT Provider HelpLine to obtain materials for display in your office, discuss any problems or questions regarding your PASSPORT clients, or enroll in PASSPORT. You can keep up with changes and updates to the PASSPORT program by reading the PASSPORT provider newsletters. Newsletters and other information are available on the Provider Information website (see *Key Contacts*). For claims questions, call Provider Relations.

Prior Authorization

Some services require prior authorization (PA) before they are provided. When seeking PA, keep in mind the following:

- The referring provider should initiate all authorization requests.
- Always refer to the current Medicaid fee schedule to verify if PA is required for specific services.
- The following table (*PA Criteria for Specific Services*) lists services that require PA, who to contact, and specific documentation requirements.
- Have all required documentation included in the packet before submitting a request for PA (see the following *PA Criteria for Specific Services* table for documentation requirements).
- When PA is granted, providers will receive notification containing a PA number. This PA number must be included in form locator 63 on the UB-92 claim form.

PA Criteria for Specific Services

Service	PA Contact	Documentation Requirements

• **All transplant services**
• **Out-of-state hospital inpatient services**
• **All rehab services**
• **Therapy services over limit for children**
	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X5850 Helena
	(800) 262-1545 X5850 In and out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In and out of state
		• Required information includes:
		  • Client's name
		  • Client's Medicaid ID number
		  • State and hospital where client is going
		  • Documentation that supports medical necessity. This varies based on circumstances. Mountain-Pacific Quality Health Foundation will instruct providers on required documentation on a case-by-case basis.

• **Emergency department reviews**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X5850 Helena
	(800) 262-1545 X5850 In and out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In and out of state
		• Required information includes:
		  • A copy of the claim
		  • A copy of the emergency department report

• **Transportation (scheduled ambulance transport, commercial and specialized non-emergency transportation)**
 	
(For emergency ambulance transport services, providers have 60 days following the service to obtain authorization (see the *Ambulance* manaul .)
	Mountain-Pacific Quality Health Foundation
	Medicaid Transportation
	P.O. Box 6488
	Helena, MT 59604
	
	Phone:
	(800) 292-7114
	Fax:
	(800) 291-7791
	E-Mail:
	ambulance@mpqhf.org
		• Ambulance providers may call, leave a message, fax, or E-mail requests.
		• Required information includes:
		  • Name of transportation provider
		  • Provider's Medicaid ID Number
		  • Client's name
		  • Client's Medicaid ID number
		  • Point of origin to the point of destination
		  • Date and time of transport
		  • Reason for transport
		  • Level of services to be provided during transport (e.g., BLS, ALS, mileage, oxygen, etc.)
		• Providers must submit the trip report and copy of the charges for review after transport.
		• For commercial or private vehicle transportation, clients call and leave a message, or fax travel requests prior to traveling.

• **Dispensing and fitting of contact lenses**	Provider Relations
	P.O. Box 4936
	Helena, MT 59604
	
	Phone:
	(406) 442-1837 Helena and out of state
	(800) 624-3958 In state
		• PA required for contact lenses and dispensing fees.
		• Diagnosis must be one of the following:
		  • Keratoconus
		  • Aphakia
		  • Sight cannot be corrected to 20/40 with eyeglasses

Multiple Services on Same Date

Outpatient hospital providers must submit a single claim for all services provided to the same client on the same day. If services are repeated on the same day, use appropriate modifiers.

Span Bills

Outpatient hospital providers may include services for more than one day on a single claim, so long as the service is paid by fee schedule (e.g., partial hospitalization, therapies, etc.) and the date is shown on the line. However, the OCE (Outpatient Code Editor) will not price APC procedures when more than one date of service appears at the line level, so we recommend billing for only one date at a time when APC services are involved.

Reporting Service Dates

- All line items must have a valid date of service in form locator (FL) 45.
- The following revenue codes require a separate line for each date of service and a valid CPT or HCPCS Level II code:

Revenue Codes That Require a Separate Line for Each Date of Service and a Valid CPT or HCPCS Code

26X	IV Therapy	51X	Clinic
28X	Oncology	52X	Free-Standing Clinic
30X	Laboratory	61X	Magnetic Resonance Imaging (MRI)
31X	Laboratory Pathological	63X	Drugs Requiring Specific Identification
32X	Radiology – Diagnostic	70X	Cast Room
33X	Radiology – Therapeutic	72X	Labor Room/Delivery
34X	Nuclear Medicine	73X	Electrocardiogram (EKG/ECG)
35X	Computed Tomographic (CT) Scan	74X	Electroencephalogram (EEG)
36X	Operating Room Services	75X	Gastro-Intestinal Services
38X	Blood	76X	Treatment or Observation Room
39X	Blood Storage and Processing	77X	Preventive Care Services
40X	Other Imaging Services	79X	Lithotripsy
41X	Respiratory Services	82X	Hemodialysis-Outpatient or Home
42X	Physical Therapy	83X	Peritoneal Dialysis-Outpatient or Home
43X	Occupational Therapy	84X	Continuous Ambulatory Peritoneal Dialysis (CAPD0-Outpatient
44X	Speech-Language Pathology	85X	Continuous Cycling Peritoneal Dialysis (CCPD)-Outpatient
45X	Emergency Department	88X	Miscellaneous Dialysis
46X	Pulmonary Function	90X	Psychiatric/Psychological Treatments
47X	Audiology	91X	Psychiatric/Psychological Services
48X	Cardiology	92X	Other Diagnostic Services
49X	Ambulatory Surgical Care	94X	Other Therapeutic Services

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT-4 book, HCPCS Level II book, and other helpful resources (e.g., CPT Assistant, APC Answer Letter and others).
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- Medicaid accepts the same modifiers as Medicare.
- The Medicaid claims processing system recognizes only one modifier. The modifier must be added to the CPT/HCPCS code without a space or hyphen in form locator (FL) 44. For example, 25680 (treatment of wrist fracture) when done bilaterally is reported as 2568050.
- Since the Medicaid claims processing system can read only one modifier per line, it is important to report the most important modifier first. In this case, the most important modifiers for Medicaid are those that affect pricing. Discontinued or reduced service modifiers must be listed before other pricing modifiers. For a list of modifiers that change pricing, see the *How Payment Is Calculated* chapter in this manual.

Billing Tips for Specific Services

Prior authorization is required for some outpatient hospital services. PASSPORT and prior authorization are different, and some services may require both (see the *PASSPORT and Prior Authorization* chapter in this manual). Different codes are issued for each type of approval and must be included on the claim form (see the *Completing A Claim* chapter in this manual).

Abortions

A completed *Medicaid Recipient/Physician Abortion Certification* (MA-37) form must be attached to every abortion claim or payment will be denied (see *Appendix A: Forms*). Complete only one part (I, II, or III) of this form; the part used must be clearly indicated on the form. This is the only form Medicaid accepts for abortions.

Drugs and biologicals

While most drugs are bundled (packaged), there are some items that have a fixed payment amount and some that are designated as transitional pass-through items (see *Pass-through* in the *How Payment Is Calculated* chapter of this manual). Bundled drugs and biologicals have their costs included as part of the service with which they are billed. The following drugs may generate additional payment:

- Vaccines, antigens, and immunizations
- Chemotherapeutic agents and the supported and adjunctive drugs used with them
- Immunosuppressive drugs

- Orphan drugs
- Radiopharmaceuticals
- Certain other drugs, such as those provided in an emergency department for heart attacks

Medicare does not cover revenue code 250 (General class pharmacy). When a client has both Medicare and Medicaid and Medicare denies the pharmacy portion of a claim, providers must report revenue code 250 on a separate UB-92 claim form when submitting the claim to Medicaid.

Lab services

If all tests that make up an organ or disease organ panel are performed, the panel code should be billed instead of the individual tests.

Some panel codes are made up of the same test or tests performed multiple times. When billing one unit of these panels, bill one line with the panel code and one unit. When billing multiple units of a panel (the same test is performed more than once on the same day), bill the panel code with units corresponding to the number of times the panel was performed.

Outpatient clinic services

When Medicaid pays a hospital for outpatient clinic or provider based clinic services, the separate CMS-1500 claim for the physician's services must show the hospital as the place of service (i.e., place of service is 22 for hospital outpatient). For imaging and other services that have both technical and professional components, physicians providing services in hospitals must also take care to bill only for the professional component if the hospital will bill Medicaid for the technical component. Refer to the *Physician Related Services* manual, *Billing Procedures* chapter for more information. Manuals are available on the Provider Information website (see *Key Contacts*)

Partial hospitalization

Partial hospitalization services must be billed with the national code for partial hospitalization, the appropriate modifier, and the prior authorization code.

Current Payment Rates for Partial Hospitalization

Code	Modifier	Service Level
H0035		Partial hospitalization, sub-acute, half day
H0035	U6	Partial hospitalization, sub-acute, full day
H0035	U7	Partial hospitalization, acute, half day
H0035	U8	Partial hospitalization, acute, full day

Sterilization

- For elective sterilizations, a completed *Informed Consent to Sterilization* (MA-38) form must be attached to the claim for each provider involved or payment will be denied. This form must be legible, complete, and accurate, and revisions are not accepted. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician.
- For medically necessary sterilizations (including hysterectomies), one of the following must be attached to the claim, or payment will be denied:
    - A completed *Medicaid Hysterectomy Acknowledgement* form (MA- 39) for each provider submitting a claim. See *Appendix A Forms*. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (section B) or life-threatening emergency (section C) exists, the client must sign and date Section A of this form at least 30 days prior to the procedure (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). The client does not need to sign this form when sections B or C are used. Please refer to *Appendix A* for more detailed instructions on completing the form.
    - For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
        - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
        - The reason for the hysterectomy was a life-threatening emergency.
        - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

For more information on sterilizations, see the *Covered Services* chapter in this manual.

Supplies

Supplies are generally bundled (packaged), so they usually do not need to be billed individually. A few especially expensive supplies are paid separately by Medicaid. Documentation of the Ambulatory Payment Classification (APC) system, available from commercial publishers, lists the supply codes that may be separately payable.